Supreme Court, U.S.
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No. 94126

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1995

BAPTIST MEMORIAL HOSPITAL

Petitioner,

v.

PAN AMERICAN LIFE INSURANCE COMPANY, MISSISSIPPI BANKERS' ASSOCIATION, Trustee of the MISSISSIPPI BANKERS' EMPLOYEES BENEFIT PLAN & TRUST, and MEMPHIS HOSPITAL SERVICE & SURGICAL ASSOCIATION, INC. d/b/a BLUE CROSS/BLUE SHIELD OF MEMPHIS,

Respondents,

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether Medicare's "working aged" rule applies in determining the priority of payments for hospital care provided to a Medicare beneficiary who also has health coverage under his own plan as a retiree and under his wife's plan as an actively working spouse.

2. Whether the "Enforcement" provisions of the Medicare as Secondary Payer statute require entry of a judgment for double damages against both employee benefit plans.

PARTIES TO THE PROCEEDING

The parties to this proceeding are set forth entirely in the caption of the case, and none of the parties are wholly owned subsidiaries or affiliates of publicly owned corporations. The parties are as follows: Baptist Memorial Hospital, a not-for-profit Tennessee corporation. Pan American Life Insurance Company, a Louisiana insurance corporation, and the Memphis Hospital Service and Surgical Association, Inc., d/b/a Blue Cross/Blue Shield of Memphis, a Tennessee insurance corporation. The Mississippi Bankers' Association, in its capacity as Trustee of the Mississippi Bankers' Employees Benefit Plan and Trust, was voluntarily dismissed.

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PETITION FOR A WRIT OF CERTIORARI

The Petitioner Baptist Memorial Hospital respectfully prays that a writ of certiorari issue to review the opinion of the Court of Appeals for the Sixth Circuit entered on February 1, 1995, and the denial of the petition to rehear, which was entered on March 30, 1995.

OPINIONS BELOW

The Opinion of the District Judge, dated July 13, 1993, is attached in the Appendix at 15a.

The opinion of the Court of Appeals, is reprinted in the Appendix at 1a. The order denying the petition to rehear is likewise reprinted in the appendix. App. at 26a. The opinion of the Court of Appeals has been published at 45 F.3d 992.

JURISDICTION

The opinion of the Sixth Circuit was entered on February 1, 1995. The petition to rehear was denied in an order dated March 30, 1995. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

Appellate jurisdiction in the Court of Appeals was invoked pursuant to 28 U.S.C. §1291, and jurisdiction in the

District Court was based upon a federal question under 28 U.S.C. §1331 since the complaint sought a declaratory judgment under the Medicare Act, 42 U.S.C. §§1395, et seq., and the Federal Employees Health Insurance Act, 5 U.S.C. §§8901, 8912.

STATUTORY PROVISIONS INVOLVED

42 U.S.C. §1395y(b). This provision is set forth at App. 33a.

STATEMENT OF THE CASE

A. Introduction.

The issue in this declaratory judgment case is which of two non-Medicare coverages of a retired Medicare beneficiary was primary for purposes of a 9-month inpatient hospitalization. The District Court ruled that the Medicare beneficiary's coverage under the plan of his actively working spouse (Pan Am) was primary. The Court of Appeals reversed, holding that the Medicare beneficiary's coverage as a retiree (Blue Cross) was primary, as between the two non-Medicare plans. The Court of Appeals, however, indicated that it would have affirmed the judgment of the District Court if Medicare had been a party or if a claim had been made for Medicare benefits.

This is a case of first impression.

Summary of Course of Proceedings

The petitioner Baptist Memorial Hospital (BMH) filed a Complaint against the respondents Pan American Life Insurance Company (Pan Am) and the Memphis Hospital Service & Surgical Association, Inc., d/b/a Blue Cross/Blue Shield of Memphis (Blue Cross), seeking a declaratory judgment as to which of these two coverages was primary for payment of hospital inpatient services provided to a Medicare beneficiary who was also covered under both plans.

The District Court ruled that Pan Am was the primary payer, Medicare was secondary and Blue Cross was tertiary. The parties stipulated as to the amount of the hospital's claim, and the District Court then ruled that Pan Am, as the primary payer, was obligated to pay double the amount of the claim under the Medicare Secondary Payer (MSP) statute, 42 U.S.C. §1395y(b).

Undisputed Facts

Horace A. Thomas received inpatient hospital services at BMH from February 13, 1990 through November 16, 1990. Mr. Thomas was a retired postal worker who was enrolled in the Medicare Program and covered under the Federal Employees Benefit Plan (FEBP) as a retiree. Mr. Thomas was also covered under the Mississippi Bankers' Association Plan because his wife was enrolled in that plan as an employee of a participating bank. Pan Am funded and

administered the Mississippi Bankers' Association Plan, and Blue Cross was the insurance carrier and administrator for the FEBP.

Horace Thomas assigned all of his health insurance benefits to BMH at the time of his admission in February 1990, and BMH submitted claims for benefits to both Pan Am and Blue Cross for the hospital's total adjusted charges in the sum of $570,049.33. Excluding certain payments such as the patient's co-payment obligation, Pan American's primary coverage obligation would be $569,349.33. Pan Am agreed that Medicare was secondary and that either it or Blue Cross was the primary payer for this claim.

Findings of the District Court

Based upon the undisputed facts in the record before it, the District Court ruled, in part, as follows:

> The "primary payer" issue is the core question in this suit. The parties agree, and the Court concurs, that the facts and law dictate that Medicare would not be the primary payer. [App. at 18a; emphasis added]

> Where an individual is covered under Medicare and an EGHP [employee group health plan] that fails to qualify under the "working aged" provisions, the preexisting rule must apply under which Medicare is primary and the EGBH [sic] secondary. On

these premises, therefore, where an EGBH [sic] covers a person by virtue of his status as a retired employee, Medicare would be the primary payer in relation to the EGBH [sic]. [App. at 21a; emphasis added]

No reported authorities exist on the issue of priority under these circumstances, but there is evidence that the implementing agency, HCFA, agrees with this interpretation. [App. at 21a]

. . . [I]t is the status of Thomas and his wife under each plan that determines the order in which the plans pay benefits . . . The Blue Cross coverage, on the other hand, does not qualify under either of the criteria of the "working aged" provisions. [App. at 22a; emphasis added]

. . . The federal law cited above [MSP statute; "working aged" regulation] supersedes conflicting provisions in a private insurers's plan. [App. at 23a]

(Order Denying Motion, etc., App. at 15a).

The Sixth Circuit's Opinion

The Court of Appeals reversed, emphasizing that the hospital purportedly failed to file a Medicare claim:

Medicare was not joined as a party, and the record does not indicate that the hospital has ever demanded payment from Medicare. **[App. 2a]**

* * *

If Medicare were involved, on the other hand, the Medicare coverage would be secondary to the Pan Am coverage but primary to the Blue Cross coverage. Under the "Medicare as Secondary Payer" statute, 42 U.S.C. §1395y(b), Medicare cannot be required to pay ahead of Pan Am. **[App. 3a; emphasis added]**

* * *

It does not appear to us, however, that the statute and implementing regulations affect the contractual arrangements under which Pan Am's coverage is secondary to that of Blue Cross -- at least where no claim is being asserted against Medicare. **[App. 3a; emphasis added]**

* * *

No such conflict [between coordination-of-benefits provisions] is apparent here, at least when Medicare is not being asked to pay. **[App. 7a; emphasis added]**

* * *

If Baptist Memorial Hospital were asserting a claim against Medicare, in addition to asserting claims against Pan Am and Blue Cross, we might have to resolve a possible conflict between the two coordinating provisions of the Blue Cross contract. **[App. 8a; emphasis added]**

* * *

> Medicare has never been asked to pay anything, as far as we know, and has not been made a party to the lawsuit. **[App. 13a; emphasis added]**

The Court of Appeals did not disagree with the District Court's analysis of the "Working Aged" rule of the MSP statute. In fact, the Sixth Circuit indicated that it would have agreed with the result reached by the District Court if it had also agreed that Medicare was involved in the case. Instead, the Court of Appeals decided the case without reference to the Medicare statutes or regulations. Unlike the District Court, the Sixth Circuit did not apply the Medicare "Working Aged" rule even though it was undisputed that Horace Thomas was a Medicare beneficiary. For the Court of Appeals, Mr. Thomas's undisputed status as a Medicare beneficiary was not enough for the "Working Aged" rule to apply.

In addition to setting forth the priority of payments among employee group health plans and Medicare, the MSP statute also contains an "Enforcement" provision in which Congress created an express private right of action against a plan which fails to make provisions for payment of primary benefits and the mandatory damages for such a failure are double the amount otherwise owed. The Court of Appeals also reversed the District Court's mandatory award of double damages against Pan Am under the MSP statute, although the Court did not disagree with the parties' agreement (and the District Court's express finding) that Medicare was not the primary payer.

REASONS FOR GRANTING THE WRIT

Summary

The Court of Appeals made its ruling based upon an erroneous understanding of the true facts material to this declaratory judgment case which was decided by the District Court on a summary judgment.

At no time in the proceedings in the District Court did Pan Am argue or even suggest that there was any significance to whether or not BMH had filed a claim with Medicare. For the first time on appeal, Pan Am (incorrectly) argued that BMH failed to submit a claim to Medicare. In fact, as set forth in detail in the Affidavit of Judy White, BMH did submit claims for Medicare reimbursement on several occasions. App. at 27a.

With respect to double damages under the MSP statute, both Pan Am and Blue Cross would be subject to the enforcement provisions of the statute, even if Blue Cross's coverage is, as the Court of Appeals ruled, primary to Pan Am's coverage, because Pan Am is still "a primary plan" with respect to Medicare, a fact that is admitted and has never been disputed. Congress enacted the "Enforcement" provision of the Medicare Act to discourage the very type of recalcitrance exhibited by the primary payer(s) in the present case. The MSP statute should be enforced by the federal courts in order to fulfill Congress's clearly stated intent that employee group health plans should be discouraged from paying benefits when they are the primary payers.

1. The patient's status as a Medicare beneficiary determines the priority of payments, regardless of whether or not Medicare is a party to this lawsuit or even if there is no evidence that a claim was made to Medicare.

No party contends that Medicare is the primary payer. The District Court made an express finding that Medicare would not be the primary payer, and the Court of Appeals did not address this question.

Under the MSP statute, employee group health plans are generally the primary payers of medical expenses and Medicare is the secondary payer. However, prior to 1981, the reverse was ordinarily true; Medicare's coverage was then generally primary to coverage under an employee plan. Congress amended the Medicare Act several times from 1981 through 1986 to reverse the order of payment for those individuals who are eligible for Medicare but who are still actively employed.[1] Under the MSP statute, the plan of an actively employed individual is primary to Medicare for medical expenses incurred by a dependant of the active

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[1]For a discussion of the general rules prior to and after the several amendments to the Medicare Act, see, Blue Cross and Blue Shield Ass'n v. Sullivan, 794 F. Supp. 1166, 1168 (D.D.C. 1992) modified sub nom., Health Insurance Association of America, Inc. v. Shalala, 23 F. 3d 412 (D.C. Cir. 1994), cert. denied, ___ U.S. ___, 115 S. Ct. 1095 (1995); United States v. Travelers Life Insurance Co., 815 F. Supp. 521 (D. Conn. 1992); Provident Life & Accident Insurance Co. v. United States, 740 F. Supp. 492, 497-500 (E.D. Tenn. 1990), appeals dismissed without opinion, 925 F.2d 1465, 1466 (6th Cir. 1991); and United States v. Blue Cross and Blue Shield of Michigan, 726 F. Supp. 1517, 1519 (E.D. Mich. 1989).

employee if the dependant also has Medicare coverage. Such individuals are known as the "working aged."

In the present case, Horace Thomas was the dependant of an active employee (his wife) who was enrolled in an employee plan (the Mississippi Bankers' Association Plan), and he had Medicare coverage.

The Secretary of Health and Human Services (HHS) is the federal official responsible for administering the Medicare Program, and she does so through the Health Care Financing Administration (HCFA). HCFA/HHS has promulgated a regulation under the express Congressional authority of the Medicare Act which controls the priority of coverages under situations such as the present case. The regulation, commonly known as the "working aged" rule, is set forth at 42 C.F.R. §411.72(a)(4).[2]

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[2]The "working aged" regulation provides, in pertinent part, as follows:

> **§411.72 Medicare benefits secondary to employer group health plan benefits.**
>
> (a) *Conditions the individual must meet.* Medicare Part A and Part B benefits are secondary to benefits payable by an employer plan for services furnished during any month in which the individual --
>
> (1) Is aged [i.e., 65 or older];
>
> (2) Is entitled to Medicare Part A benefits . . .
>
> (3)Is not entitled . . . to Medicare on the basis of end-stage renal disease . . .; and

The issue in this case has always been which of these two non-Medicare coverages is primary, presupposing that a claim would eventually be made to Medicare if all charges were not paid by the primary payer's coverage. Since the only issue was which payer was primary, the Secretary of Health and Human Services (HHS) was not a necessary party to this litigation.[3] However, the fact that the Secretary of HHS is not a necessary party does not mean that Medicare's coverage is eliminated as a factor in the equation. The patient's enrollment in the Medicare Program is a crucial element in determining the priority of coverages for purposes of determining the primary payer.

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(4) Meets one of the following conditions:

(i) Is employed and covered, by reason of that employment, under an employer plan.

(ii) Is the aged spouse of an employed individual who -

(A) For services furnished before January 1985 . . .; or

(B) For services furnished after January 1, 1985 through April 30, 1986 . . .; or

(C) For services furnished after April 30, 1986 was, at the time the services were furnished, any age.

42 C.F.R. §411.72(a)(4)(emphasis added).

[3]Medicare as such would not be the proper party. The proper party would actually be the Secretary of Health and Human Services.

There is no dispute that Medicare's coverage is not primary, and the Secretary's obligations are set forth quite clearly in the statutes and regulations. As a party, the Secretary would have nothing to add to the debate as to which of these two non-Medicare plans was the primary payer.

Moreover, it is questionable whether the Secretary of HHS could have been made a party to this lawsuit. The Medicare Act establishes judicial review of a final decision by the Secretary, and it incorporates the exclusive judicial review provisions of the Social Security Act. See, 42 U.S.C. §1395ii and 42 U.S.C. §405. The latter statute prohibits an action in federal court for "any claim arising under" the Act against the Secretary pursuant to the federal question statute, 28 U.S.C. §1331, or the United States as a party statute, 28 U.S.C. §1346. Weinberger v. Salfi, 422 U.S. 749 (1975); Heckler v. Ringer, 466 U.S. 602 (1984); but see, Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986).

Finally, the Sixth Circuit was inconsistent in its application of the MSP statute. In determining the priority of coverages between Pan Am and Blue Cross, the Sixth Circuit did not take into account Horace Thomas's status as a Medicare beneficiary.[4] Instead, the Court of Appeals

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[4]Another serious flaw in the Sixth Circuit's reasoning in excluding Medicare's coverage as a factor to be considered because Medicare was not "implicated," is that the Court is apparently assuming that the extent of Blue Cross's coverage is identical to the coverage provided under Pan Am's policy. However, there is no evidence in the record on this issue, and it is conceivable that Medicare may ultimately be called upon to pay

purposely removed Medicare from its consideration of the issue, since, it held (incorrectly), that no Medicare claim was filed. On the other hand, in ruling that the hospital could not enforce its private right of action for double damages, the Court relied on the terms the Blue Cross policy and the language of the MSP statute.

2. The Court of Appeals erred in Ruling as a Matter of Fact that BMH did not file a Medicare claim.

i. The Issue of whether a Medicare claim was filed was improperly raised for the first time on appeal and the Court of Appeals erred in considering the issue.

Neither Pan Am nor Blue Cross raised any issue in the District Court as to whether BMH submitted a claim for Medicare benefits. Therefore, since the only issue was which of the non-Medicare coverages was primary, no evidence was presented to the District Court in this regard. It is undisputed, however, that Mr. Thomas was enrolled in the Medicare Program. Thus, Mr. Thomas's status as a Medicare beneficiary was undisputed, and the issue of Medicare's involvement in this case was never questioned in the District Court. Indeed, the District Court expressly held that it was the patient's *status* as a Medicare beneficiary and

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a portion of Mr. Thomas's hospital bill, in which case Medicare's coverage would most certainly be "implicated." This potential outcome is another reason why appellate courts are prohibited from ruling on issues that are raised for the first time on appeal: the record in such cases are often void of significant evidence.

under each plan which determined the order in which the plans pay benefits.

For the first time on appeal, Pan Am argued that BMH did not file a claim for Medicare benefits. It is a long-standing principle of jurisprudence that an appellate court should not pass on issues not raised at the trial level. This Court has recognized this basic rule as being essential "in order that the parties may have the opportunity to offer all the evidence they believe relevant to the issues . . . [and] in order that litigants may not be surprised on appeal by a final decision there of issues upon which they have had no opportunity to introduce evidence." Hormel v. Helvering, 312 U.S. 552, 556 (1941), Singleton v. Wulff, 428 U.S. 106, 121 (1976).

BMH was surprised by the argument made for the first time on appeal by Pan Am that the hospital did not file a claim for Medicare benefits. As a result, BMH was unable to include any evidence in the record to refute this incorrect assertion. It is clear that the Court of Appeals accepted Pan Am's erroneous statements as true and that this erroneous belief was the basis for its ruling that Medicare's coverage was not a factor to be considered in this case.

ii. The Court of Appeals reviewed the record under the wrong standard in considering the motion for summary judgment as to whether the hospital made a claim for Medicare reimbursement, and there is a genuine issue as to a material fact in that regard.

Pan Am's position in the District Court was that its coverage was primary to Medicare's coverage but that its coverage was not primary to Blue Cross's coverage. Pan Am never argued in the District Court that the issue of whether BMH submitted a claim for Medicare benefits was even remotely material to this case.

In fact, contrary to the ruling of the Court of Appeals, BMH submitted several claims to the Medicare intermediary for payment of this claim. As set forth in the Affidavit of Judy White, there were numerous telephone conversations between the Medicare intermediary and BMH regarding the claims. Following these communications, Medicare denied the claim and advised the hospital that it would not make a conditional payment because the primary payer simply refused to pay. Affidavit of Judy White, App. at 28a-32a.

As demonstrated above, it is immaterial whether a claim was submitted to Medicare for this hospitalization. Nevertheless, the Court of Appeals should not have resolved this question since there was no evidence in the record on the issue and it is, in fact, a disputed and unresolved issue.

The standard for ruling on a motion for summary judgment is that the evidence submitted to the Court must be viewed in the light most favorable to the party opposing the motion. Matsushita Electric Industrial Co. v. Zenith Radio Corp., 475 U.S. 572, 587 (1986). Under Rule 56 of the Federal Rules of Civil Procedure, summary judgment is appropriate only where the pleadings, discovery material and affidavits show that there is no genuine issue of material fact

and the moving party is entitled to a judgment as a matter of law.

There was no evidence in the record as to whether a claim was made to Medicare. Despite the absence of proof in this regard, the Court of Appeals found as a matter of fact that no claim was filed,[5] and in so ruling, the Court did not view the evidence in the light most favorable to the non-moving party (BMH), nor did it draw all justifiable and reasonable inferences in favor of BMH. On the contrary, it appears that the Court actually reached conclusions from the

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[5]The Court of Appeals apparently was influenced by factual assertions made by Pan Am in its brief to that court which were false and unsupported by any evidence in the record. At page 5 of its brief, Pan Am incorrectly stated, without citation to the record, "No claim was made to Medicare." Also, at page 24, again without citation to the record, Pan Am made the following statements:

> . . . As private group health plans generally pay more than Medicare's allowable charges, the Hospital knew full well that it was much better off treating Mr. Thomas as a private plan beneficiary rather than as a Medicare beneficiary.
>
> Despite the Hospital's effort to preserve the private, non-Medicare aspect of its claim for its economic benefit, as reflected in its conscious decision to make a claim against the private insurers rather than to Medicare, it nevertheless wishes to invoke a Medicare penalty provision to further augment its potential recovery. . .

(Brief at 24)(emphasis added). Finally, at page 31 of its brief, Pan Am repeated its incorrect statement that ". . . no claim was made to Medicare . . ."

record that were least favorable to the non-moving party in contravention of the appropriate standard of review.

3. The double damages enforcement provisions of the MSP statute apply to both Blue Cross and Pan Am even if Blue Cross is required to pay before Pan American because they are both primary payers under the MSP statute.

The enforcement provisions[6] of the MSP statute are simple: A primary plan which fails to make primary payments when Medicare is the secondary payer is subject to a private cause of action for damages which shall be in an amount double the amount otherwise owed. If, as the Court of Appeals ruled, Blue Cross pays before Pan Am, then Blue Cross is a primary payer and the double damages enforcement provision of the MSP statute should apply.

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[6]The private "Enforcement" portion of the MSP statute reads in its entirety as follows:

> **Enforcement**
>
> **(A) Private cause of action**
>
> There is established a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a primary plan which fails to provide for primary payment (or appropriate reimbursement) in accordance with such paragraphs (1) and (2)(A).

42 U.S.C. §1395y(b)(3)(emphasis added).

The Court of Appeals ruled that Blue Cross was primary to Pan Am for purposes of primary coverage in this case. Both Pan Am and Blue Cross are, therefore, primary payers (with respect to Medicare), because Pan Am has admitted that its coverage is primary to Medicare, and Blue Cross's coverage can only be primary to Pan Am if it, too, is primary to Medicare.

Under the plain language of the MSP statute, both of these primary plans are liable for double damages, because the statute is not limited in its application to only one plan. Instead, it states that "a" primary plan that fails to make primary payments is subject to a private cause of action for the failure to provide for primary payment. Pan Am has never argued that it's coverage is not primary to Medicare. Therefore, it is a "primary plan" which has not made primary payment.

For purposes of determining which of the non-Medicare plans is primary, the Court of Appeals held that Medicare's coverage was not a factor to be considered, absent a showing that a claim was made for Medicare reimbursement. Yet, for purposes of applying the double damages provisions of the MSP statute, the Court did consider the presence of Medicare's coverage, holding that Blue Cross is not subject to the statute because its coverage is secondary to Medicare. If Medicare's coverage is determinative for purposes of Blue Cross's liability for double damages, then it must also be determinative for purposes of the priority of coverages.

Conclusion

This is a case of first impression, and the question of the priority of coverages for Medicare beneficiaries is extremely important in view of the wide concern for the payment of the costs of health care for the elderly. It was important enough for Congress to not only specifically set forth the rules for the priority of payments, but to also create a private right of action to discourage primary payers from failing to fulfill their legal obligations.

The District Court correctly applied the straightforward provisions of the MSP statute to require the employee health benefit plan of the actively working spouse of a Medicare beneficiary to be the primary payer and to pay double damages for its failure to pay such primary benefits. The Court of Appeals incorrectly ruled that the patient's undisputed status as a Medicare beneficiary was insufficient for the "Working Aged" rule of the MSP statute to apply. The Court of Appeals also improperly considered an issue that was raised for the first time on appeal and it incorrectly determined a matter of fact that was not considered by the District Court and on which there was no evidence in the record.

The petitioner BMH respectfully submits that the Court should issue a writ of certiorari to the Court of Appeals for the Sixth Circuit.

Respectfully submitted,

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